U.S. Department of Labor

Office of Administrative Law Judges
Seven Parkway Center - Room 290
Pittsburgh, PA 15220

(412) 644-5754
(412) 644-5005 (FAX)

Issue date: 07Mar2002

CASE NO.: 2001-BLA-742

In the Matter of:

FRANCES POWELL Survivor of WALTER POWELL,
Claimant

v.

BETH ENERGY MINES INC.,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES:

Debra L. Henry, Esq.
For the Claimant

Carl J. Smith, Jr., Esq.
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER – AWARDING SURVIVOR'S BENEFITS

This proceeding arises from a claim for benefits filed by Frances Powell, the surviving spouse of Walter A. Powell, a now deceased coal miner, under the Black Lung Benefits Act, 30 U.S.C. Section 901, *et seq*. Regulations implementing the Act have been published by the Secretary of Labor in Title 20 of the Code of Federal Regulations.

Black lung benefits are awarded to coal miners who are totally disabled by pneumoconiosis caused by inhalation of harmful dust in the course of coal mine employment and to the surviving

dependents of coal miners whose death was caused by pneumoconiosis. Coal workers' pneumoconiosis is commonly known as "black lung disease." The Act and Regulations define pneumoconiosis as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

PROCEDURAL HISTORY

The miner, Walter Powell, filed an initial claim for black lung benefits on April 27, 1981. Miner's claim was denied by the Claims Examiner of the Office of Workers' Compensation Programs ("OWCP"), Robert F. Bender, per a letter dated August 14, 1981 for failure to: (1) establish miner suffers from pneumoconiosis; (2) establish pneumoconiosis was caused in part by coal mine work; and (3) to show that he was totally disabled by the disease. Since no action was taken by miner within the 60 days provided, the claim was deemed abandoned. However, by a letter dated January 7, 1982, miner requested to reopen his claim and sought reconsideration of the denied claim. In a letter dated June 3, 1986, miner's claim for benefits was again denied by Claims Examiner, Nora Chang, for failure to establish total disability due to pneumoconiosis.

Miner timely requested a formal hearing on July 31, 1986 and the matter was initially referred to the Office of Administrative Law Judges on October 30, 1986. However, in a letter dated April 20, 1987, the claimant acknowledged that he had insufficient evidence to establish eligibility. On December 17, 1987 per Order of ALJ William G. Roylance, an Order of Dismissal was entered granting miner's request that the scheduled January 13, 1988 hearing be dismissed. Thus, the initial claim was finally closed.

During this same time, Mr. Powell had also filed an employee's Claim Petition for compensation under the provisions of the Pennsylvania Workmen's Compensation Act against Bethlehem Mines Corporation for total disability as of August 30, 1984 from coal workers' pneumoconiosis allegedly contracted during his mine employment. In a Decision by the Commonwealth of Pennsylvania, Department of Labor and Industry, Bureau of Workers' Compensation, the Referee Frank C. Roney held Mr. Powell's claim petition should be dismissed as Mr. Powell was not entitled to benefits under the Pennsylvania Workers' Compensation Act. The Referee found Mr. Powell was "not totally or partially disabled from silicosis, anthracosilicosis, coal workers' pneumoconiosis, or any other work-related occupational disease."

However, on May 18, 1988, the Commonwealth of Pennsylvania, Department of Labor and Industry, per a Decision by Referee Frank C. Roney found Mr. Powell "became totally and permanently disabled on January 28, 1987 due to coal worker's pneumoconiosis as a result of his exposure to a coal dust hazard in the Commonwealth of Pennsylvania for a period of at least two years preceding the date of disability." Therefore, the Referee held that Mr. Powell was entitled to "compensation at a rate of $125.00 per month beginning January 28, 1987 and continuing thereafter for

each month of total and permanent disability during his lifetime only, in accordance with the Pennsylvania Occupational Disease Act."

Further, on April 26, 1989, miner filed a new claim for black lung benefits under the Act. Per a Decision and Order by the Deputy Commissioner of OWCP, John E., Ciszek, dated September 15, 1989, miner's new claim for benefits was denied as there was "no material change in claimant's condition" and miner "failed to establish total disability or death due to pneumoconiosis arising out of coal mine employment."

Miner appealed the decision and the matter was ultimately referred to the Office of Administrative Law Judges for adjudication by Order of the Benefits Review Board, dated January 29, 1991. A formal hearing was held before ALJ Morin on November 12, 1991. On December 18, 1992 a Decision and Order by ALJ Morin was issued denying benefits, as miner failed to establish total disability due to pneumoconiosis or by any other means under the Act.

Miner died on December 6, 1999 at the age of eighty-two. Subsequent to ALJ Morin's December 18, 1992 Decision and Order and miner's death, the parties held a conference in order to stipulate uncontested and contested issues on January 12, 2000. The sole stipulated contested issue was whether the miner's death was due to pneumoconiosis.

Following the conference, Frances Powell ("Mrs. Powell"), widow of miner, filed a claim for Black Lung benefits on June 30, 2000. Beth Energy Mines, Inc. filed a Operator Response Form, dated August 11, 2000, denying the claim of "responsible operator" on the basis that the miner did not have pneumoconiosis and miner's death was not caused by pneumoconiosis.

In a Notice of Initial Finding, dated October 6, 2000, by Claims Examiner Jean M. Farneth, Mrs. Powell was informed of an initial finding of entitlement on her claim for Black Lung benefits. The responsible operator, Beth Energy Mines, Inc., contested the District Director's finding and requested a formal hearing, but the District Director decided an informal conference would be useful to narrow the issues in the claim. In addition, Beth Energy Mines, Inc. submitted an Operator Controversion In The Form Of A Statement of Contested Issues on November 2, 2000 stating, among other things, that it would neither begin benefit payments nor reimburse the Black Lung Disability Trust Fund for payments made by the trust thus far.

The informal conference was held on January 12, 2001 where Mrs. Powell's attorney, Patsy Riccuiti appearing for Debra L. Henry, was present, along with Beth Energy Mines, Inc.'s counsel, Carl J. Smith, Jr. A thorough consideration of all evidence and issues was permitted during the conference. The District Director of OWCP, Colleen S. Smalley, in a Memorandum of Informal Conference, dated January 30, 2001, determined the issue of whether miner's death was caused at least in part by pneumoconiosis could not be resolved in the claimant's behalf and would continue to be contested by the Director and the employer, Beth Mines Energy, Inc. Therefore, the District Director decision of

October 6, 2000, finding Mrs. Powell entitled to benefits on her claim, was reversed and Mrs. Powell's claim for Black Lung benefits was denied.

A timely request for a formal hearing was made by Mrs. Powell and a hearing was held on October 3, 2001. I was assigned the case on October 3, 2001.

ISSUES

Whether the miner's death was due to coal workers' pneumoconiosis.

FINDINGS OF FACT

I.Background

A. Survivorship

The parties do not dispute and I find the claimant is an eligible survivor of the minor. She has not remarried.

B. Coal Miner

There is no dispute that the claimant's husband was a coal miner, within the meaning of Section 402(d) of the Act and Section 725.202 of the Regulations.

C. Date of Filing

The matter was not contested by the parties and I find none of the Act's filing time limitations are applicable; thus, the claim was timely filed.

D. Responsible Operator

The responsible operator is Beth Energy Mines, Inc.

E. Dependents

Miner's only dependent is survivor and claimant, Francis Powell. Francis Powell has no dependents.

F. Personal and Employment Histories

The miner, Walter Powell, was born on February 22, 1917 and completed an eighth grade education. He married his wife, Francis, on April 14, 1941. Francis Powell is miner's sole dependent for purposes of receipt of benefits under the Act.

Miner smoked approximately one-third pack of cigarettes daily for 22-50 years, ending in 1982. However, other medical reports indicate miner may have used tobacco more extensively. Miner is unable to recall the smoking histories he provided to various physicians over the years.

The miner alleged approximately forty-plus years of coal mine employment with Bethlehem Mines Corporation. During his employment, miner worked as a Coal Loader, General Inside Laborer, Cutting Machine Operator, and Machine Repairman. Miner worked in a number of mines during his employment. He began working in the coal mines in 1935 and retired in 1980. From 1942 until 1945, miner did not work in the mines, as he was in the U.S. Armed Forces. Miner had numerous jobs all inside the mine except during his last year of employment. During his last year of employment, miner worked as an outside mechanic repairing machinery. Miner retired in 1980 because he was "tired all the time, his legs were weak, and he was extremely sleepy."

The death certificate indicates miner died on December 6, 1999 at the age of eighty-two. The immediate cause of death was pulmonary edema and the underlying cause was severe aortic stenosis. Other significant condition contributing to death was history of peptic ulcer disease. The certifier was Dr. Alvaro Changco.

I.Medical Evidence

Medical Records

The Washington Hospital records indicate miner was hospitalized once in 1991, three times in 1992, once in 1997, twice in 1998 and once in 1999. The records of the Allegheny General Hospital indicate miner was hospitalized twice in 1994. COPD was an ongoing diagnosis since 1992. Miner's medical history included, amongst other health problems, severe aortic stenosis, pneumothrorax, gastric ulcer that later presented as a bleeding peptic ulcer, coronary artery disease, and congestive heart failure from 1998 until his death in 1999. During his last hospitalization, Dr. Alvaro N. Changco noted in his physical examination that miner is an "82-year-old, white male who is in extreme distress at the time of admission." Dr. Changco also noted that miner's heart was irregular, rales was present in both lung fields and his abdomen was slightly distended. Dr. Changco's diagnosis and assessment was "acute pulmonary edema. Consider a cardiac event such as myocardial infraction which is developing. The patient also has severe aortic stenosis which is probably the cause of all of his medical problems." The plan of treatment included diuresis, cardiology consult and reinstituting miner's prior medications.

A chest x-ray was conducted on December 6, 1999 and according to Dr. John A. Beel, the x-ray indicated dyspnea. In comparison to December 5, 1999, the x-ray revealed that miner's heart was enlarged. The impressions from the x-ray included: "(1) cardiomegaly; (2) right pleural effusion; and (3) bilateral lower lung infiltrates which appear interstitial on the left and interstitial and alveolar on the right. This may be related to congestive failure. That on the right may also be related to pneumonia. Pulmonary vascularity shows slight improvement." A subsequent chest x-ray was conducted on miner and dictated by Dr. Kenneth A. Edgar who indicated SOB in his final report. Dr. Edgar's impressions included, "Cardiomegaly and moderate to large bilateral pleural effusions and moderate central venous congestion and interstitial pulmonary edema suggesting congestive heart failure. These findings have worsened since the exam of the prior day and are new from August 18, 1999."

REASON FOR HOSPITALIZATION: Following miner's death, Dr. Changco, miner's treating physician, summarized the following: "The patient was admitted on 12/5/99, expired on 12/6/99. The cause of death is acute pulmonary edema secondary from severe aortic stenosis and possible myocardial infraction." Miner was admitted with symptoms of "pulmonary edema, shortness of breath, atrial fibrillation, and had been treated accordingly with diuresis, oxygen and medication that he had been taking previously." A cardiology consultation was started on miner, but was not completed because miner's condition worsened. Miner developed "severe shortness of breath and gurgling of the chest, leading him to cease breathing." Dr. Changco's diagnosis is that miner had "severe pulmonary edema with concomitant acute myocardial infraction."

SIGNIFICANT FINDINGS: Claimant requested to have an autopsy performed. Dr. Cyril H. Wecht conducted the autopsy on December 7, 1999. Dr. Wecht reviewed various medical records and other relevant documents per request of Claimant's attorney. In a letter to Claimant's attorney, dated May 19, 2000, Dr. Wecht concluded miner "suffered from pneumoconiosis prior to his death. Specifically, I believe that his pulmonary pathology was coal worker's pneumoconiosis." Dr. Wecht based his diagnosis upon "Mr. Powell's occupational, medical, and social history, and confirmed by the autopsy findings." Dr. Wecht further states in his opinion, "Mr. Powell died as a result of marked cardiomegaly with severe biventricular hypertrophy. . .and that [miner's] coal worker pneumoconiosis, which was the basis for his chronic obstructive pulmonary disease, was a substantial contributing factor in his death." In making his clinical diagnosis of pneumoconiosis, Dr. Wecht made the following findings:

> The micoscopic autopsy tissues slides which I have prepared show diffuse depositions of black anthracotic pigment in the peribronchiolar and periarteriolar lymphatics. Ruptured alveolar walls, consistent with pulmonary emphysema, pulmonary fibrosis, thickening of the pleura with subpleural deposits of anthracotic pigment, fibrohyaline and fibroanthracotic macules and micronodules,

and fibrohyalinization and fibroantracosis of peribronchial lymph nodes, are also noted. In addition, examination of lung tissue under polarized light reveals scattered birefringent crystals, consistent with silica. All these findings in the lungs are compatible with the antemortem history and a clinical diagnosis of pneumoconiosis.

Dr. Wecht further emphasized that "the disease process of coal worker's pneumoconiosis, which was a substantial contributing factor in Mr. Powell's death, had manifested itself through various clinical signs and symptoms for several years preceding this gentleman's terminal illness and death."

Physicians' Reports

There are a total of nine physicians' reports by Drs. Cappiello, Changco, Fino, Green, Lapp, Levine, Naeye, Tarwater, and Wecht, their findings are set forth below.

Dr. Francis H.Y. Green reviewed the medical and other pertinent records, as well as the autopsy report and slides in determining whether miner had pneumoconiosis and, if so, whether this caused or contributed to his death. Dr. Green's findings as of 7/27/01 were as follows:

1. Upon examining the lungs, the most prominent feature is the presence of pneumoconiosis, comprised predominately of silicotic nodules with an associated interstitial fibrosis. The silicotic nodules range in size from 0.2 mm to 0.7 mm. Polarizing microscopy shows large quantities of birefringent particles consistent with silica within these nodules. Confluent silicotic nodules are also seen in the tracheo-bronchial lymph nodes. Coal dust macules with focal emphysema and coal worker's micronodules are also seen. Black pigment, consistent with coal mine dust, is seen within the lesions of pneumoconiosis and adjacent lung parenchyma. In addition to pneumoconiosis, there is a moderately severe emphysema, predominately centriacinar in type, characterized by enlarged airspaces and fragmentation of the airspace walls. The lungs also show chronic congestion of the lungs with numerous hemosiderin-laden cells in the alveolar spaces.

2. Based on review of the medical record, including the autopsy report and review of the autopsy materials, it is my view that Mr. Powell died as a result of congestive cardiac failure (with pulmonary edema). Mr. Powell had a combination of left-and right-sided heart disease. The left-sided disease was due to hypertension and severe aortic stenosis. The right-sided disease (*cor pulmonale*) was a result of COPD and pneumoconiosis. Hence, in my opinion, death resulted from a combination of cardiac and pulmonary disease.

3. Miner had been evaluated for black lung on many occasions during his life. Of 30 or more x-rays taken, approximately one-third were read as positive for pneumoconiosis, whereas the others were read as negative. The autopsy, however, confirmed the presence of

pneumoconiosis, and it is well known that the radiograph is less sensitive than pathology and may give abnormally low readings in the presence of confounding diseases, such as emphysema. The autopsy revealed macules with focal emphysema as well as micro- and macronodules the largest of which showed features of silicosis. In addition, there was an interstitial component to the fibrosis, a feature characteristic of silica exposure.

4. Miner was exposed to both coal mine dust and cigarette smoke. His smoking history varies, however the records indicate that he smoked approximately one-half to one pack per day for 22-50 years, quitting in 1982. He was a moderately heavy smoker and this would undoubtedly have contributed to his COPD. However, based on the numerous epidemiological and clinical studies, the coal mine dust was also a major factor of his COPD.

5. The pneumoconiosis (including the dust-related component of the COPD) contributed to death in several ways. First, the combined lung disease was sufficiently severe to cause right ventricular hypertrophy and right heart strain. The autopsy showed clear evidence of right heart hypertrophy (*cor pulmonale*) with a right ventricular wall thickness of 7-8 mm (normal is up to 3 mm). Hence, the pneumoconiosis contributed to cardiac failure and cardiac death. Secondly, there was evidence that Mr. Powell suffered from episodes of myocardial ischemia, due in part to coronary artery atherosclerosis but also due to hypoxemia secondary to the lung disease. Third, miner suffered from a treatable cardiac condition, aortic stenosis. The records indicate that when his aortic stenosis was causing episodes of heart failure he was not considered eligible for surgery because of other co-morbid conditions, notably his COPD/pneumoconiosis. Thus, the presence of the dust-induced lung disease made him ineligible for curable cardiac surgery. Age was also given as a factor for not proceeding with surgery, and certainly this is a factor, but in an otherwise fit and healthy individual, age would not preclude this type of cardiac surgery.

Upon review of Dr. Green's July 1, 1998 curriculum vitae, Dr. Green is board certified to practice medicine in Alberta, Canada and West Virginia, U.S.A. Dr. Green is currently a professor in the Department of Pathology and Co-Chair of the Respiratory Research Group at the University of Calgary in Alberta, Canada.

Dr. Richard L. Naeye, in a 12/22/00 letter to Beth Energy Mines, Inc.'s counsel, reviewed miner's occupational history, pertinent medical records, death certificate, autopsy report and twenty-one glass slides with tissues removed from the autopsy in reaching the following conclusions:

1. The findings of a mild, simple coal worker's pneumoconiosis (CWP) are present. It is far too limited in extent to have caused any measurable abnormalities in lung function, any disability or to have hastened this man's death. This evaluation is strongly supported by the mild abnormalities this man had on pulmonary function studies and arterial blood gas

analyses. The latter abnormalities were the consequence of his many years of smoking cigarettes. It is also substantiated by the minimal or absent findings of CWP on the many chest x-rays obtained over the years.

2. His dyspnea on exertion was caused by a combination of his obesity, severe cardiac calcific valvular stenosis, and hypertension. Another contribution to this dyspnea was the damage to the microcirculation of his heart caused by his many years of cigarette smoking. His pulmonary emphysema was almost entirely the consequence of his many years of cigarette smoking.

3. Airway obstruction caused by centrilobular emphysema and bronchitis that is severe enough to preclude a miner from working is very rare if indeed it occurs at all in the absence of smoking or complicated CWP. The 8 mm thickness of this man's right cardiac ventricle was not the result of CWP or any other lung disorder. It was the consequence of chronic left sided heart failure whose genesis was mainly the result of severe cardiac aortic valvular stenosis and hypertension.

Furthermore, in a 8/9/01 letter to Beth Energy Mines, Inc.'s counsel, Dr. Naeye reviewed Dr. Francis H.Y. Green's 7/27/01 findings and made the following determinations:

1. [Dr. Green claimed] the severe right cardiac ventricular hypertrophy present in Walter Powell was chronic cor pulmonale, i.e. caused by lung disease and CWP in particular. . . . [Dr. Naeye finds] the CWP was far too mild to have caused any degree of cor pulmonale because it affected <1% of [miner's] lung parachyma. This is easily substantiated by the fact that 2/3rds of the interpretations of chest x-rays were negative for CWP. CWP severe enough to have caused chronic cor pulmonale would have been easily recognized on all of the x-rays.

2. I strongly disagree with Dr. Green's assertions that free silica caused interstitial fibrosis in the lungs of Walter Powell. It is true that large amounts of free silica characteristically cause interstitial fibrosis. However that fact is irrelevant in the present case because there are far too few crystals of toxic free silica in the lungs of Walter Powell to cause such lesions. Most of the birefringent crystals present are far too large to be free silica. They are non-toxic silicates. Dr. Green in his report does not distinguish between the two. Furthermore, what superficially appears to be interstitial fibrosis in the lungs of Walter Powell is mainly the fusion of ruptured alveolar walls.

3. Overall, it appears that mine dust has only about 20% of the effect of heavy cigarette smoking in the genesis of this disorder in coal miners. Walter Powell reportedly smoked a pack of cigarettes for 25-55 years. He was thus a very heavy cigarette smoker. Even more important, Walter Powell's pulmonary function studies found evidence of only minor

abnormalities as late as 1991. There is no basis for postulating clinically significant chronic lung disease of any sort in this man.

4. Dr. Green's analyses and conclusions about lung disease in Walter Powell are mainly based on generalizations from the literature and the unrepresentative tissues removed at autopsy. Reference to the *quantitative* results of pulmonary function studies, arterial blood gas analyses and chest x-ray interpretations make it clear that Walter Powell's CWP was too mild to have caused any measurable abnormalities in lung function, disability or to have contributed in any way to his death.

Dr. Naeye is board certified with the American Board of Pathology since 1956. He is currently a University Professor of Pathology at The Pennsylvania State University College of Medicine in Hershey, Pa.

Dr. Gregory J. Fino examined miner on three occasions prior to his death, 10/23/91; 9/27/89; and 3/18/87.[1] Dr. Fino reviewed the miner's pertinent medical records and evaluations, x-rays, death certificate, autopsy report, and the pathological reviews by Dr. Green dated 7/27/01 and Dr. Naeye dated 12/22/01 and 8/9/01 and found as follows in a 9/10/01 report:

1. This man died as a result of significant coronary artery disease. . . . Based on the clinical information. . .available, there is no evidence whatsoever that this man's coal workers' pneumoconiosis played any role in his death.

2. If someone had such severe chronic obstructive pulmonary disease plus severe cor pulmonale, which contributed to death, it would certainly be expected that this would have been a longstanding diagnosis. . . . However, that was not the case. Furthermore, clinical evaluations and echocardiography did not confirm that.

3. All pulmonary function studies done in this case did not show any evidence of chronic obstructive pulmonary disease resulting in severe enough condition to cause cor pulmonale. His last pulmonary function study showed a mild obstruction that improved following the use of bronchodilator medication; this is inconsistent with a coal mine dust-related pulmonary condition.

4. Taking all of this into consideration, I can state with a reasonable degree of medical certainty that this man's death was neither caused nor contributed to through the inhalation

[1] Dr. Gregory J. Fino has also given deposition testimony before the U.S. Department of Labor on 10/23/91 and 11/9/01 that is consistent with his medical findings and conclusions contained within his 9/10/01 report with respect to miner's medical history and death. *See* deposition 10/23/91, pages 22-53 and deposition 11/9/01, pages 28-46.

of coal mine dust. Coal mine dust inhalation did not hasten his death. This man would have died as and when he did had he never stepped foot in the mines.

Dr. Fino is board certified in Internal Medicine with a Subspecialty in Pulmonary Disease since 1982. He maintains a private practice in lung diseases in Pittsburgh, Pa. Dr. Fino is also certified as a B-Reader for chest x-rays through January 2005.[2]

Dr. Macy I. Levine examined miner on two occasions prior to his death, 10/3/91 and 3/27/89. In a report dated 10/10/91, Dr. Levine reached the following conclusions:

1. Miner's pulmonary function test "showed reductions of FVC, FEV-1, FEV-3, FEF 25-75, and vital capacity. These were changes of both obstructive and restrictive pulmonary disease." In comparison to miner's pulmonary function test on March 27, 1989, the "present pulmonary function test shows decreases in FVC, FEV-1, FEV-3, and vital capacity. . .indicating that the respiratory condition has progressed over the past two and a half years."

2. Miner's chest x-ray showed "linear opacities throughout both lungs compatible with pneumoconiosis category 1/0 – s/s in six zones."

3. Diagnoses: 1) Pneumoconiosis due to coal dust; 2) Chronic bronchitis; 3) History of hypertension; and 4) Obesity.

4. Dr. Levine commented "patient is totally and permanently disabled due to pneumoconiosis due to coal dust. His condition is due to his total cumulative exposure to coal dust during his entire working experience in the coal mines."

Dr. Levine's 4/3/89 report included the following findings:

1. Pulmonary function study "showed a mild reduction in FEV-1, FEV-3, FEV-1/FVC, and FEF 25-75. These changes are those of obstructive lung disease."

[2] A B-reader must demonstrate proficiency in assessing and classifying x-ray evidence for pneumoconiosis by successful completion of an examination conducted by, or on behalf of, the Appalachian Laboratory for Occupational Safety and Health (ALOSH). In the examination, the physician must evaluate x-ray studies for quality and must use the ILO-U/C classification system. A B-reader has demonstrated expertise in assessing and classifying x-ray evidence for pneumoconiosis, and has been approved as a proficient reader by the National Institute for Occupational Safety & Health, pursuant to 42 C.F.R. Section 37.51 (1982).

2. Chest x-ray "showed the heart to be at the upper border of normal in width. The lungs showed small rounded and irregular opacities in the two lower zones of each lung compatible with pneumoconiosis category 1/0 – p/s in four zones."

3. Dr. Levine's comments in the 4/3/99 report included that, "The patient had a long exposure to coal dust in the coal mines and has developed early changes of pneumoconiosis on the chest x-ray film."

Dr. Levine is board certified in Internal Medicine since 1958 with a subspecialty in Allergy since 1962. Dr. Levine was licensed to practice medicine in Pennsylvania in 1944. Currently, Dr. Levine is on the active staff of Presbyterian-University Hospital, Montefiore Hospital and St. Margaret Hospital. Dr. Levine also serves as a consultant in chest disease at the New Kensington Clinic.

Dr. Enrico Cappiello conducted a chest x-ray on miner on 8/18/99 and made the following evaluations in his report:

1. There is borderline cardiomegaly without congestive heart failure or infiltrate. There are changes of chronic obstructive pulmonary disease. There are many small rounded parenchymal opacities throughout both lungs varying in size from a fraction of a millimeter up to approximately 3 mm. in diameter. There are no large opacities however there are coalescent opacities left lung. There is right and left chest wall pleural thickening less than 5 mm. in thickness.

2. Impression: Pneumoconiosis category p/q, profusion 2/1; Chronic obstructive pulmonary disease (em); Coalescent opacities (ax); Right chest wall pleural thickening, Grade A, extent 2; Left chest wall pleural thickening, Grade B, extent 2.

Dr. Cappiello is board certified by the American Board of Radiology, December 1978.[3] He has a Subspecialty in Angiography, Cardiac Radiology and Special Procedures. Dr. Cappiello is certified as a "B" Reader from October 1987 to present.[4]

---

[3] A Board-certified radiologist is certified in radiology or diagnostic roentgenology by the American Board of Radiology or the American Osteopathic Association. Requirements for this classification include four years of postgraduate training followed by successful completion of comprehensive written and oral examinations. A portion of the oral examination is devoted to testing the candidate's proficiency of diagnosing diseases of the lungs.

[4] See supra note 2.

Dr. Doyle L. Tarwater examined miner on 1/28/87 and made the following findings:

1. "The lungs were clear to auscultation and percussion. Cardiac exam showed a grade 3/6 aortic stenosis type murmur, loudest at the base of the heart radiating to the carotids and the apex."

2. Pulmonary function tests showed a "FVC predicted of 4.20L, measured at 3.15L for 75% of predicted. FEV1 predicted 2.84, measured 2.35 for 83% predicted. The MVV predicted was 122L per minute, his best try was 102L per minute, for 84% of predicted. This is interpreted as a mild reduction of the FVC with no expiratory obstruction. His blood gases showed a pH of 7.42, pCO2 of 41.6, pO2 of 76.2, this is interpreted as showing hypoxia.

3. The chest x-ray showed slight cardiac enlargement, and coal workers' pneumoconiosis, IALO classifications 1/1, p/p, 6 zones.

4. Conclusions: ". . .with 42 years of coal dust exposure, with. . .no other medical history that can explain his respiratory impairment, with a grossly abnormal chest x-ray, hypoxia blood gas, and mild restrictive disease on spirometory, it is my considered medical opinion with a reasonable degree of medical certainty, that Mr. Walter Powell is completely disabled from his last job or any meaningful physical activities secondary to coal workers' pneumoconiosis. The only explanation of his disability is coal workers' pneumoconiosis. His pneumoconiosis is secondary to 42 years of coal dust inhalation in his work in the coal mining industry."

Dr. N. LeRoy Lapp[5] evaluated miner for pulmonary evaluation on 10/2/81 and 3/15/85 at the request of Bethlehem Mines and provided the following report on 10/5/81:

1. Diagnoses included, "1. Hypertensive and arteriosclertotic heart disease. 2. Chronic bronchitis with minimal terminal slowing."

2. Conclusions after evaluation, "There is insufficient evidence for a medical diagnosis of coal workers' pneumoconiosis. He has chronic bronchitis with minimal terminal slowing which I attribute to his cigarette smoking. The degree of terminal slowing is not sufficient to be a respiratory or pulmonary impairment that would cause disability. His hypertensive and arteriosclerotic heart disease are naturally occurring and not a consequence of his occupational exposure. On the basis of this examination including the history of his job

[5] Dr. N. Leroy Lapp has also given deposition testimony before the Commonwealth of Pennsylvania, Department of Labor and Industry on 6/27/85 that is consistent with his medical findings and conclusions contained within his 10/5/81 report. *See* deposition 6/27/85, pages 50-53, 69-92.

performed as a miner, I would state that he has no respiratory impairment that would preclude him from performing the job that he formerly did prior to his retirement."

Dr. Lapp is board certified in Internal Medicine since February 1969 with a Subspecialty in Pulmonary Diseases since June 1978. He was initially certified as a "B" reader by the National Institute for Occupational Safety and Health in 1973 through 1977. Dr. Lapp was last recertified as a "B" reader from 5/01/89 to 4/30/93.[6] He is currently a professor in the Department of Medicine at West Virginia University School of Medicine. Dr. Lapp is also presently on active staff at West Virginia University Medical Center, Director of Pulmonary Function Laboratory at Ruby Memorial Hospital of West Virginia University Hospitals, Inc., and Medical Director of Respiratory Care Services at Ruby Memorial Hospital of West Virginia University Hospitals, Inc.

Witness Testimony

The claimant testified during a hearing before ALJ Morgan on October 3, 2001 that in miner's later years of coal mine employment, prior to retirement, that miner was "usually pretty tired" when he came home from work. Claimant also stated that over the years, miner's breathing become worse and that he had a cough. Miner would do little things and get out of breath, he couldn't cut the grass or hedges anymore because of his breathing problems, and even going up steps or walking a grade caused miner to become out of breath. With respect to miner's smoking history, claimant stated miner did not have much time to smoke because he worked ten hour days and slept eight hours. Further, claimant estimated that miner stopped smoking "five or six years ago," therefore, in approximately 1995 or 1996.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Entitlement/Denial of Benefits

1. Survivor's Claim

Part 718 applies to survivors' claims which are filed on or after April 1, 1980. 20 C.F.R. Section 718.1. There are four possible methods of analyzing evidence in a survivor's claim under Part 718: (1) where the survivor's claim is filed prior to January 1, 1982; (2) the survivor's claim is filed prior to January 1, 1982 and there is no living miner's claim or the miner is not found entitled to benefits as the result of a living miner's claim filed prior to January 1, 1982; (3) the survivor's claim is filed after January 1, 1982 and the miner was found entitled to benefits as the result of a living miner's claim filed prior to January 1, 1982; and (4) the survivor's claim is filed after January 1, 1982 where there is no living miner's claim filed prior to January 1, 1982 or the miner is found not entitled to benefits as a result

[6] See supra note 2.

of a living miner's claim filed prior to January 1, 1982. The fourth set of conditions applies to this claim, as survivor filed her claim after January 1, 1982 and the miner was found not entitled to benefits as a result of a living miner's claim filed prior to January 1, 1982. 20 C.F.R. Section 718.205(c).

Part 718 regulations provide that a survivor is entitled to benefits only where the miner *died due to pneumoconiosis*. 20 C.F.R. Sections 725.212(a)(3), 725.218(a)(2), 725.222(a)(5), and 718.205(a). As a result, the survivor of a miner who was totally disabled due to pneumoconiosis at the time of death, but died due to an unrelated cause, is not entitled to benefits. 20 C.F.R. Section 718.205(c).

A survivor is automatically entitled to benefits only where the miner was found entitled to benefits as a result of a claim filed prior to January 1, 1982. However, a survivor is no longer automatically entitled to such benefits under a claim filed on or after January 1, 1982 where the miner is not entitled to benefits as a result of the miner's claim filed prior to January 1, 1982 or where no miner's claim was filed prior to January 1, 1982. Neely v. Director, OWCP, 11 B.L.R. 1-85 (1988). In addition, the survivor is not entitled to the use of lay evidence, or the presumptions at Sections 718.303 and 718.305 to aid in establishing entitlement to survivors' benefits.

It is noteworthy that in Trumbo v. Reading Anthracite Co., 17 B.L.R. 1-85 (1993), the Board held that in a Part 718 survivor's claim, the administrative law judge must make a threshold determination as to the existence of pneumoconiosis under 20 C.F.R. Section 718.202(a) prior to considering whether the miner's death was due to the disease under Section 718.205.

A. Existence of Pneumoconiosis

Under the Act, pneumoconiosis is defined as:

> (a) . . .a chronic lung disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or 'clinical', pneumoconiosis and statutory, or 'legal', pneumoconiosis.
>
> (1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e. the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) *Legal Pneumoconiosis*: "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(3) For purposes of this definition, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(b) For purposes of this definition, "pneumoconiosis is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 C.F.R. Section 718.201 (revised, August 2001).

There are a total of nine physicians involved in this case. Five are treating physicians: Drs. Changco (miner's family physician), Fino (examined miner three times prior to death), Levine and Lapp (both examined miner twice prior to death), and Tarwater (examined miner once prior to death). One physician performed the autopsy, Dr. Wecht. Two physicians are non-treating and reviewed miner's medical records, autopsy report and slides, Drs. Green and Naeye. Dr. Fino only reviewed the autopsy report and not the slides. One physician performed a chest x-ray, Dr. Cappiello. Drs. Cappiello, Fino and Naeye are B-readers.[7] The qualifications for Drs. Changco and Tarwater are unknown.

Autopsy evidence is the most reliable evidence of the existence of pneumoconiosis.[8] In this case, Dr. Wecht conducted the autopsy and concluded that miner suffered from coal workers' pneumoconiosis prior to death. Dr. Wecht based his conclusions on miner's occupational, medical, social history and autopsy findings. Dr. Wecht's findings in miner's lungs were compatible with the antemortem history and clinical diagnosis of pneumoconiosis. The evidence relevant to Dr. Wecht finding pneumoconiosis includes: (1) anthracotic pigment in the peribronchiolar and periarteriolar lymphatics; thickening of the pleura with subpleural deposits of anthracotic pigment[9]; (2) emphysema: ruptured alveolar walls, consistent with pulmonary emphysema and pulmonary fibrosis[10]; and (3)

---

[7] See supra note 2.

[8] Terlip v. Director, OWCP, 8 B.L.R. 1-363 (1985). *See also* Peabody Coal Co. v. McCandless, 255 F.3d 465 (7th Cir. 2001).

[9] *See* Lykins v. Director, OWCP, 819 F.2d 146 (6th Cir. 1987) (holding the administrative law judge must also consider biopsy evidence with indicates the presence of anthracotic pigment).

[10] Robinson v. Director, OWCP, 3 B.L.R. 1-798.7 (1981) (asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure).

Chronic obstructive pulmonary disease: miner's coal workers' pneumoconiosis was the basis for his chronic obstructive pulmonary disease.[11]

The opinions of Drs. Naeye, Green, Fino, Levine, Cappiello and Tarwater are consistent with the autopsy evidence.

- Dr. Naeye reviewed miner's medical records, occupational history, death certificate, autopsy report and slides in finding the existence of mild, simple coal worker's pneumoconiosis.
- Dr. Green similarly reviewed miner's medical records along with the autopsy report and slides and determined the presence of pneumoconiosis in miner's lungs upon finding silicotic nodules with associated interstitial fibrosis, black pigment consistent with coal mine dust, moderately severe emphysema and chronic congestion of the lungs. Dr. Green also found, although miner was a moderately heavy smoker, the coal mine dust was a major factor in his COPD.
- Dr. Fino similarly notes the existence of coal workers' pneumoconiosis in miner's lungs.
- Dr. Levine examined miner twice prior to his death and her last report of 10/10/91 found changes in miner's pulmonary tests that were indicative of obstructive and restrictive pulmonary disease; a chest x-ray showed "linear opacities throughout both lungs compatible with pneumoconiosis category 1/0 – s/s in six zones"; and diagnosed miner as suffering from pneumoconiosis due to coal dust.
- Dr. Cappiello's chest x-ray of 8/18/99 showed borderline cardiomegaly and changes of COPD. Dr. Cappiello similarly found pneumoconiosis category p/q.
- Dr. Tarwater examined miner on 1/28/87 and found miner's chest x-ray showed slight cardiac enlargement and coal worker's pneumoconiosis, IALO classifications 1/1, p/p, 6 zones. Dr. Tarwater explained that miner's pneumoconiosis is secondary to 42 years of coal dust inhalation in his work in the coal mining industry.

Dr. Lapp's findings are outweighed by the other opinions of record, as his findings provide the earliest evidence of record. The Board has previously held that because pneumoconiosis is a progressive and irreversible disease, it may be appropriate to accord greater weight to the most recent evidence of record, especially where a significant amount of time separates newer evidence from that evidence which is older.[12] Dr. Lapp evaluated miner on 10/2/81 and concluded there was insufficient

---

[11] The amended regulations specifically provide that "a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. Section 718.201(b) (Dec. 20, 2000). Moreover, the definition of "legal pneumoconiosis" specifically "includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment." 20 C.F.R. Section 718.201(a)(2) (Dec. 20, 2000).

[12] Clark v. Karst-Robbins Coal Co., 12 B.L.R. 1-149 (1989) (en banc); Casella v. Kaiser Steel Corp., 9 B.L.R. 1-131 (1986).

evidence for a medical diagnosis of coal workers' pneumoconiosis. Miner died approximately eighteen years after seeing Dr. Lapp for evaluation; therefore, more recent evidence in the record finding the existence of pneumoconiosis is accorded greater weight. Further, Dr. Lapp does not provide an explanation on what basis he believes miner's coal dust exposure did not contribute to miner's respiratory problems and heart disease.

Dr. Alvaro Changco, miner's family physician, does not provide evidence in the record as to the existence of pneumoconiosis in miner's lungs. Dr. Changco was the certifier of miner's death certificate and found the immediate cause of death to be pulmonary edema with an underlying cause of severe aortic stenosis. Other significant condition contributing to death was noted as history of peptic ulcer disease. A death certificate, in and of itself, is an unreliable report of the miner's condition and it is error for an administrative law judge to accept conclusions contained in such a certificate where the record provides no indication that the individual signing the death certificate possessed any relevant qualifications or personal knowledge of the miner from which to assess the cause of death.[13] In this case, Dr.Changco did have a thorough knowledge of miner's medical history. However, Dr. Changco's relationship as treating physician should not be accorded any greater weight, it must be considered in light of all relevant evidence in the record.[14]

Out of nine physicians, seven find the existence of pneumoconiosis in miner's lungs. Dr. Changco does not make an attempt to explain on what basis he believes coal mine dust exposure did not contribute to miner's respiratory problems, other medical tests, or death. Dr. Lapp's findings are too early in miner's medical history to conclusively provide a finding of pneumoconiosis, as pneumoconiosis is a progressive disease and miner was examined by Dr. Lapp eighteen years prior to his death.

Therefore, upon weighing all the evidence, I find claimant has established the existence of pneumoconiosis.

A. Death due to Pneumoconiosis

Subsection 718.205(c) applies to survivor's claims filed on or after January 1, 1982 and provides that death will be due to pneumoconiosis if any of the following criteria are met:

(1) competent medical evidence established that the miner's death was due to pneumoconiosis; or

---

[13] Smith v. Camco Mining, Inc., 13 B.L.R. 1-17 (1989); Addison v. Director, OWCP, 11 B.L.R. 1-68 (1988).

[14] Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, 65 Fed. Reg. 79, 334 (Dec. 20, 2000).

(2) pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or the death was caused by complications of pneumoconiosis; or

(3) the presumption of Section 718.304 [complicated pneumoconiosis] is applicable.

20 C.F.R. Section 718.205(c).

The evidence of record establishes miner's pneumoconiosis was a substantially contributing cause or factor leading to miner's death. Therefore, miner's death due to pneumoconiosis can be established pursuant to Section 718.205(c)(2).

The United States Court of Appeals for the Third Circuit held that any condition that *hastens* the miner's death is a substantially contributing cause of death for purposes of Section 718.205.[15] The Fourth, Sixth, Seventh, and Tenth Circuits have adopted this position in Shuff v. Cedar Coal Co., 967 F.2d 977 (4th Cir. 1992), cert. denied, 113 S. Ct. 969 (1993); Brown v. Rock Creek Mining Corp., 996 F.2d 812 (6th Cir. 1993) (J. Batchelder dissenting); and Peabody Coal Co. v. Director, OWCP, 972 F.2d 178 (7th Cir. 1992); Northern Coal Co. v. Director, OWCP, 100 F.3d 871 (10th Cir. 1996) (a survivor is entitled to benefits if pneumoconiosis hastened the miner's death "to any degree"). Further, the amended regulations have added a subsection to 20 C.F.R. Section 718.205(c) that adopts the "hastening death" standard and provides the following: "pneumoconiosis is a 'substantially contributing cause' of a miner's death if it hastens the miner's death." 20 C.F.R. 718.205(c)(5) (Dec. 20, 2000).

Survivors are not eligible for benefits where the miner's death was caused by traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death. 20 C.F.R. Section 718.205(c)(4). Neeley v. Director, OWCP, 11 B.L.R. 1-85 (1988) (survivor not entitled to benefits where the miner's death was due to a ruptured abdominal aortic aneurysm).

Miner's death certificate indicates the immediate cause of death as acute pulmonary edema, underlying cause as severe aortic stenosis, and significant contributing factor to death as miner's history of peptic ulcer disease. As discussed earlier, a death certificate, in and of itself, is an unreliable report of the miner's condition and it is error for an administrative law judge to accept conclusions contained in such a certificate where the record provides no indication that the individual signing the death certificate possessed any relevant qualifications or personal knowledge of the miner from which to assess the cause of death.[16] In this case, Dr. Alvaro Changco, miner's family physician, signed the death certificate and had a thorough knowledge of miner's medical history. Nonetheless, Dr. Changco's relationship as treating physician should not be accorded any greater weight, it must be considered in

[15] Lukosevicz v. Director, OWCP, 888 F.2d 1001 (3d Cir. 1989).

[16] See supra note 13.

light of all relevant evidence in the record.[17] Moreover, it is important to consider the Board has held that autopsy reports must be accorded significant probative value regarding the existence and degree of pneumoconiosis because the pathologist who performs the autopsy sees the entire respiratory system as well as other body systems.[18]

Dr. Wecht, who is board-certified in pathology, concluded in the autopsy report that miner's coal workers' pneumoconiosis, which was the basis for his chronic obstructive pulmonary disease, was a substantial contributing factor in his death which had manifested itself through various clinical signs and symptoms for several years prior to his death. Dr. Green similarly found pneumoconiosis (including the dust-related component of COPD) contributed to miner's death based on: (1) combined lung disease was sufficiently severe to cause right ventricular hypertrophy (cor pulmonale) and right heart strain; (2) miner suffered from episodes of myocardial ischemia, due in part to coronary artery atherosclerosis and hypoxemia secondary to lung disease; and (3) miner suffered from treatable aortic stenosis, but miner was inoperable due to his other co-morbid conditions, notably COPD and pneumoconiosis.

Dr. Fino, a B-reader[19], found miner died as a result of significant coronary artery disease and concluded there is no evidence whatsoever that miner's coal workers' pneumoconiosis played any role in his death. However, the findings of Dr. Fino are of less weight for several reasons. First, Dr. Fino reviewed miner's autopsy report and the pathological reviews of Drs. Green and Naeye, but did not review the autopsy slides. The Board has held it is "reasonable to assign greater weight to the opinion of the physician who performs the autopsy over the opinions of others who review his or her findings without reviewing the slides."[20] Second, Dr. Fino's reliance upon pulmonary function studies in making his conclusions regarding miner's chronic obstructive pulmonary disease is not persuasive. It appears Dr. Fino is implying that miner's respiratory problems were likely due to his smoking history, as Dr. Fino opinioned miner would have died as he did had he never stepped foot in the mines. However, the 6th Circuit Court has held that a medical opinion attributing the miner's respiratory impairment to his smoking history on the grounds that pulmonary function testing produced a purely obstructive defect was not well-reasoned.[21] Third, Dr. Fino only examined miner on three occasions, the last examination occurring on 10/23/91, approximately eight years prior to miner's death. According to Dr. Fino, if miner had such severe COPD plus cor pulmonale, it would have been a longstanding diagnosis. Yet, the Board has previously held that because pneumoconiosis is a progressive and irreversible disease, it may be appropriate to accord greater weight to the most recent evidence of record, especially where a

---

[17] Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, 65 Fed. Reg. 79, 334 (Dec. 20, 2000).

[18] Fetterman v. Director, OWCP, 7 B.L.R. 1-688, 1-691 (1985). *See also* Northern Coal Co. v. Director, OWCP, 100 F.3d 871 (10th Cir. 1996) (holding it was proper for the administrative law judge to accord greater weight to the opinion of an autopsy prosector over the opinions of reviewing pathologists).

[19] See supra note 2.

[20] Terlip v. Director, OWCP, 8 B.L.R. 1-363 (1985); Fetterman v. Director, OWCP, 7 B.L.R. 1-688 (1985). *See also* U.S. Steel Corp. v. Oravetz, 680 F.2d 197, 200-201 (3d Cir. 1982).

[21] Cornett v. Benham Coal, Inc., 227 F.3d 569 (6th Cir. 2000).

significant amount of time separates newer evidence from that evidence which is older.[22] Therefore, miner's severe COPD plus cor pulmonale may not have presented itself as a long standing condition upon Dr. Fino's 1991 examination, but such a finding does not negate the fact that miner's COPD plus cor pulmonale could have presented itself severely as miner's pneumoconiosis disease progressed from 1991 up until his death in 1999.

While acknowledging miner suffered from pneumoconiosis, Dr. Naeye, a B-reader[23], concluded it was far too limited in extent to have caused any measurable abnormalities in lung function, any disability or to have hastened miner's death. Dr. Naeye's opinions are those of a non-treating physician and he did not participate in the autopsy. The Board has held that an administrative law judge may accord less weight to a consulting or non-treating physician's opinion on grounds that he or she does not have first-hand knowledge of the miner's condition.[24] Also, greater weight may be accorded to a physician who performs the autopsy over one who reviews the autopsy slides.[25] In fact, the Board has held that autopsy reports must be accorded significant probative value regarding the existence and degree of pneumoconiosis because the pathologist who performs the autopsy sees the entire respiratory system as well as other body systems.[26]

In addition, Dr. Naeye's findings are of less weight because he relies upon pulmonary function studies, arterial blood gas analyses and chest x-ray interpretations in reaching his conclusions. Pulmonary function studies are not diagnostic of the presence or absence of pneumoconiosis.[27] Although, blood gas studies are relevant primarily to the determination of the existence or extent of impairment, such evidence may also indicate the absence of disease arising out of coal mine employment.[28] Dr. Naeye indicates there were mild abnormalities in miner's arterial blood gas analyses and that such abnormalities were the consequence of miner's many years of smoking. Dr. Naeye also states that miner's pulmonary emphysema was almost entirely the consequence of miner's smoking. The Board has held that the results of blood gas and pulmonary function testing "may consistently have no correlation since coal workers' pneumoconiosis may manifest itself in different types of pulmonary impairment." *See* Tussey v. Island Creek Coal Co., 982 F. 2d 1036, 1040-41 (6th Cir. 1993).

---

[22] See supra note 12.

[23] See supra note 2.

[24] Bogan v. Consolidation Coal Co., 6 B.L.R. 1-1000 (1984). *See* Lange v. Director, OWCP, 104 F.3d 573 (3d Cir. 1997*). See also* Cole v. East Kentucky Collieries, 20 B.L.R. 1-51 (1996) (the administrative law judge acted within his discretion in according less weight to the opinions of the non-examining physicians; he gave their opinions less weight, but did not completely discredit them). *But see*, Chester v. Hi-Top Coal Co., 22 B.L.R. _, BRB No. 00-1000 BLA (2001) and Collins v. J.& L Steel, 21 B.L.R. 1-182 (1999).

[25] Similia v. Bethlehem Mines Corp., 7 B.L.R. 1-535 (1984); Cantrell v. U.S. Steel Corp., 6 B.L.R. 1-1003 (1984).

[26] See supra note 18. I note criticism of this approach outside the Third Circuit.

[27] Burke v. Director, OWCP, 3 B.L.R. 1-410 (1981).

[28] Morgan v. Bethlehem Steel Corp., 7 B.L.R. 1-226 (1984).

Upon weighing all the evidence, I find the mutually supportive opinions of Drs. Wecht and Green to outweigh the other opinions in the record. Dr. Wecht conducted the autopsy and had an opportunity to evaluate miner's entire respiratory system and other body systems. Dr. Green evaluated miner's medical records, autopsy report and slides. The regulations specifically provide that autopsy reports must be given significant probative value as to the existence and degree of pneumoconiosis because the pathologist who performs the autopsy sees the entire respiratory system and other body systems.[29] Both physicians found miner's pneumoconiosis was a contributing factor to his death that manifested itself through various clinical symptoms over several years prior to miner's death.

Therefore, I find claimant has established miner's death was due to pneumoconiosis. Accordingly, she is entitled to benefits under the Act.

A. Attorney fees

An application by the claimant's representative for approval of a fee has not been received; therefore, no award of representative's fees for services is made. Thirty days is hereby allowed to the claimant's counsel for submission of such an application. Counsel's attention is directed to 20 C.F.R. Sections 725.365-725.366. A service sheet showing that service has been made upon all parties, including the claimant, must accompany the application. Parties have ten days following receipt of an application within which to file any objections. The Act prohibits charging of a fee in the absence of an approved application.

CONCLUSIONS

In conclusion, the claimant has established that miner's pneumoconiosis was a substantial contributing cause to death and that his death was due to pneumoconiosis. She is therefore entitled to survivor's benefits.

ORDER

The claims of Frances Powell, widow of Walter Powell, for benefits under the Act are **GRANTED**. It is hereby **ORDERED** that the Black Lung Disability Trust Fund shall pay to the claimant, Frances Powell, survivor's benefits.

A
RICHARD A. MORGAN
Administrative Law Judge

RAM:VAG:dmr

[29] See supra note 18.

PAYMENT IN ADDITION TO COMPENSATION: 20 C.F.R. Section 725.530(a) (applicable to claims adjudicated on or after January 20, 2001) provides that "[a]n operator that fails to pay any benefits that are due, with interest, shall be considered in default with respect to those benefits, and the provisions of Section 725.605 of this part shall be applicable. In addition, a claimant who does not receive any benefits within **10 days** of the date they become due is entitled to additional compensation equal to **twenty percent** of those benefits (see Section 725.607)."

NOTICE OF APPEAL RIGHTS: (**Revisions effective January 19, 2001**): Pursuant to 20 C.F.R. Section 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board before the decision becomes final, *i.e.*, at the expiration of thirty (30) days after "filing" (or **receipt by**) with the Division of Coal Mine Workers' Compensation, OWCP, ESA, ("DCMWC"), by filing a Notice of Appeal with the **Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601.**[30] A copy of a Notice of Appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, at the Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

[30] 20 C.F.R. Section 725.479 (change effective January 19, 2001).